

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 110-6

CERTIFICATE OF DEATH

Reg. Dist. No. 10403 337

1. PLACE OF DEATH:

County Wicomico
 City or town Wetipquin
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? not at all

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Wetipquin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

John Wesley Bailey
 4. Sex Male 5. Color or race aa 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife

Bertha Ellen Bailey 8.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.)

May 12, 1898
 8. AGE: Years 48 Months 4 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace

Wetipquin, Wicomico Co., Maryland
 (Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Same as above

MOTHER FATHER

12. Name Pembroke Bailey

13. Birthplace Wetipquin, Maryland

14. Maiden name Adeline Allen

15. Birthplace Wetipquin, Maryland

16. Informant Mrs. Bertha Bailey

Address Wetipquin, Maryland

17. Burial Date thereof 10-6-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Conway

Location Wetipquin, Maryland

18. Funeral director James F. Stewart

Address 402 E. Church St., Salisbury, Md.

19. Oct 6 19 46 R. D. Melford Walter
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

212-16-7868

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3-46 19_____, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 46 to 10-3-46

and that I last saw him alive on 10-3-46 19_____.
 Immediate cause of death Congestive Heart Failure

Due to Pleurisy & Effusion DURATION 72 hr

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert F. Stewart M. D. or other _____

Address Conway Date signed 10-6-46

RECEIVED

OCT 15 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

10404

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury Peninsula General Hosp.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 days
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 211 Second
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Banks, Frances L.

3. (b) Social Security Number

no

4. Sex Female 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife -
 6. (c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) 7-1-1897
 8. AGE: Years 49 Months 3 Days 6 If less than one day - hrs. - min.

9. Birthplace Phila. Phila Co., Pa.
 (Town, county, and state)
 10. Usual occupation Teacher
 11. Industry or business Public School
 12. Name J. Henry Banks
 13. Birthplace Aquasco Maryland
 14. Maiden name Susan E. Warfield
 15. Birthplace New Bedford Mass.

16. Informant Samuel W. Banks
 Address Preston, Maryland
 17. Burial Burial Date thereof 10-12-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Merion
 Location Merion, Pa.

18. Funeral director James F. Stewart
 Address 402 E. Church St. Salisbury Md.

19. 10/10, 1946 Harriet E. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1946 at - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-6 1946 to 10-8 1946 and that I last saw her alive on 10-8-46 1946

Immediate cause of death Central Hemorrhage
Hypertension.

Due to -
 Due to -
 Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Philip A. Insley M. D. or other -
 Address Salisbury Md. Date signed 10-8-46

RECEIVED

OCT 16 1946

BUREAU V B

Reg. Dist. No. 330.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Accomie
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new born infants give residence of mother)
State.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Harry Woodland Bounds
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Married
7. Birth date of deceased (mo., day, yr.) Feb. 21st 1885
8. AGE: Years 61 Months 7 Days 13 If less than one day hrs. min.
9. Birthplace Siloam Maryland
10. Usual occupation Farmer
11. Industry or business

MOTHER
FATHER
12. Name Hester Bounds
13. Birthplace Siloam Md.
14. Maiden name Elizabeth Malone
15. Birthplace Siloam Md.

16. Informant Mrs. Nellie Lee Bounds
Address P.O.#1, Mandela, Maryland
Burial Oct. 7-1946
Date thereof (month) (day) (year)
Cemetery or crematory Mandela Cem.
Location Mandela, Maryland
Funeral director Hillman & Co. Baltimore
Address Salisbury Maryland
Date rec'd by registrar 10/7/46 Registrar W.H. Robertson

MEDICAL CERTIFICATION
20. DATE OF DEATH Oct. 4th 1946 at 10 P.M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 4th 1946 to Oct. 4th 1946 and that I last saw him alive on Oct. 4th 1946
Immediate cause of death Hemorrhage Throat
DURATION
Due to...
Due to...
Other conditions...
(Include pregnancy within 3 months of death)
Major findings of operations...
Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.
21. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?
SIGNATURE William E. Smith M.D. or Other
Date signed Oct. 5-46

RECEIVED
OCT 12 1946
BUREAU V F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10406399

1. PLACE OF DEATH:

County Dickens
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicCity or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Brown Baby

3. (b) Social Security Number

4. Sex male 5. Color or race e 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Oct. 5, 1946

8. AGE:

Years

Months

Days

If less than one day

3

hrs.

min.

9. Birthplace

P. O. B. Salisbury, Wic, Md
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____

14. Maiden name

Brown, Dorothy

15. Birthplace

Mardella Md.

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Mardella Cem.

Location

Mardella, Md.

18. Funeral director

Address

19.

(Date rec'd by registrar)

10/8/461946Wic

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1946 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____

to

19 _____

and that I last saw him _____ alive on _____ 18 _____

Immediate cause of death

Prematurity

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

L. R. Grooms M.D.
 M. D. or other

Address

Salisbury, Md.

Date signed

10/8/46

RECEIVED

OCT 16 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1954)

CERTIFICATE OF DEATH

10407

Reg. Dist. No. 333

1. PLACE OF DEATH: "Wicomico"
 County.....
 City or town.....Salisbury R.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....32 years
 Hospital, institution, or street address where death occurred:
 Quantico Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Wicomico
 City or town.....Salisbury R.D. 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Quantico Road
 (If rural, give LOCATION)
 World War 11
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Charles Ralph Culver

3.(b) Social Security Number

4. Sex.....Male
 5. Color or race.....White
 6.(a) Single, married, widowed, or divorced.....Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age.....years
 7. Birth date of deceased (mo., day, yr.).....November 13, 1914
 8. AGE: Years.....31 Months.....10 Days.....18 If less than one day.....hrs.min.

9. Birthplace.....Salisbury, Wicomico, Maryland
 (Town, county, and state)
 10. Usual occupation.....Farmer
 11. Industry or business.....
 12. Name.....Harold S. Culver
 13. Birthplace.....Wicomico Co., Maryland
 14. Maiden name.....Edna E. Mc Glaug
 15. Birthplace.....New York, Brooklyn

16. Informant.....Mrs. Harold S. Culver
 Address.....Salisbury, Maryland
 17. Burial Date thereof.....October 3, 1946
 (Burial, cremation, or removal. Which?).....(month) (day) (year)
 Cemetery or crematory.....Parsons
 Location.....Salisbury, Maryland
 18. Funeral director.....The Hill & Johnson Co.
 Address.....Salisbury, Maryland

19. 10/3, 1946 Date rec'd by registrar.....
 19. 10/3, 1946 Date signed by registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....October 1 1946 at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from.....
 and that I last saw.....alive on.....
 Immediate cause of death.....asphyxiation

Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....None
 Date of op.....
 Autopsy results.....None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide.....accident Date of.....10/1/46
 Where did injury occur?.....Salisbury Wicomico Md
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....Farm home
 Means of injury.....Fell asleep smoking cigarette Injured at work? No

23. SIGNATURE.....J. Rademaker M.D.
 Address.....Salisbury, Md
 Date signed.....10/3/46

DURATION
 sudden
 death

RECEIVED
OCT 10 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

Country WisconsinCity or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wic.City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 4
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Davis (Quinn I.)

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

9. Birthplace

Salisbury, Wisconsin
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 9 October 1946 at 9⁰⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 October 1946 to 9 October 1946and that I last saw him alive on 8 October 1946

Immediate cause of death

Prematurity

DURATION

2 daysDue to Cause not determined.One of identical twins.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 21 1/2 Camden Ave Date signed 9 Oct 1946Salisbury, Md.

MARGIN RESERVED FOR BINDING

VS A15

9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10408

333

RECEIVED
OCT 16 1946
BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10409

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wilcomica
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since 1905
 Hospital, institution, or street address where death occurred: none
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Wilcomica
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 501 Pearl St
 (If rural, give LOCATION)
 2(a) If veteran, name war no

3. (a) FULL NAME

Mary E Dixon

3. (b) Social Security Number

213-12-5288

4. Sex female 5. Color or race a.d. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William Dixon
 Yes Yes 6. (c) If alive, give age has, known years
 7. Birth date of deceased (mo., day, yr.) About 1888
 8. AGE: Years about 58 Months - Days - If less than one day - hrs. - min.

9. Birthplace Daniels Quarter md
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Same as above
 12. Name Herry A Jones
 13. Birthplace Daniels Quarter
 14. Maiden name Roxana Jones
 15. Birthplace Daniels Quarter md

16. Informant Wm Dixon
 Address Salisbury md
 17. Burial Date thereof Oct 10 - 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Daniels Quarter
 Location Daniels Quarter
 18. Funeral director James H. Stewart
 Address Salisbury, md.
 19. 10/10, 1946 Registrar James H. Stewart
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 19 46 at 9³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from seen dead 19 -

and that I last saw him alive on 19 -

Immediate cause of death Coronary occlusion

Due to -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of Injury - Injured at work? -

23. SIGNATURE Wm Dixon M. D. or other

Address Salisbury, md Date signed 10/8/46

RECEIVED
JUN 16 1946
BUREAU V B

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Smiley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 10410 333

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

I certify that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 10-9-46

RECEIVED

OCT 16 1946

BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 490

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wilcombe
 City or town Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? more than weeks
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wilcombe
 City or town Salisbury, Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Katie Duffield

3. (b) Social Security Number

no

4. Sex

female

5. Color or race

a.a.

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife William L. Duffieldyes6. (c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.)

about 1884

8. AGE:

Years

Months

Days

If less than one day

about 62--hrs.

min.

9. Birthplace Warrenton Friendship
(Town, county, and state)10. Usual occupation Housewife11. Industry or business same as above12. Name Geaige Harmon13. Birthplace Salisbury14. Maiden name Maryhester Parker15. Birthplace Salisbury16. Informant Mardelle JohnsonAddress Salisbury Md17. Burial Burial Date thereof Nov 1 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory FriendshipLocation Warrenton18. Funeral director James H. StewartAddress Salisbury Md19. 11/1 19 46
(Date filed by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 19 46 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 19 46 to Oct. 29 19 46and that I last saw him alive on 10 - 28 19 46Immediate cause of death Pneumonia

DURATION

Due to PneumoniaDue to Carcinoma of ovary

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Flora A. Smith

M. D. or other

Address Salisbury Md Date signed 10-29-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 7 1946
BUREAU V.B.

2-35

1534

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1752

10412

Reg. Dist. No. 333

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

3 days

3. (a) FULL NAME

Dutton, Paul

3. (b) Social Security Number

4. Sex

male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Edith Dutton

7. Birth date of deceased (mo., day, yr.)

August 28, 18996. (c) If alive, give age 42 years

8. AGE:

Years

Months

Days

If less than one day

4723

hrs.

min.

9. Birthplace

Delmar, Sussex County, Delaware
(Town, county, and state)

10. Usual occupation

Day laborer

11. Industry or business

Marine Package Company

MOTHER FATHER

12. Name

Ldney Morris

13. Birthplace

Wicomico County, Maryland

14. Maiden name

Katie Dutton

15. Birthplace

Trappe, Maryland

16. Informant

Mrs. Edith Dutton

Address

Delmar, Maryland

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof November 4, 1946
(month) (day) (year)

Cemetery or crematory

Union Cemetery

Location

Near Delmar, Maryland

18. Funeral director

J. F. Traubman & Son

Address

Edwardsburg, Maryland

19.

11/4/46
(Date filed by registrar)

19.

Harriet E. Johnson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Wicomico

City or town

Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No.

13 West Chestnut Street

(If rural, give LOCATION)

2. (a) If veteran, name war

9

MEDICAL CERTIFICATION

20. DATE OF DEATH

10 - 31

19.

46 at 4:16 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him in hospital 19 46 10 31 19

Immediate cause of death

Broken neck.

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Spinal cord injury

Date of op.

10/28/46

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidentDate of 10/28/46Where did injury occur? Near Delmar
(City or town)Wicomico md
(County) (State)

Injured at home, farm, industry, public place (where?)

working in woodsMeans of injury Tree fell on himInjured at work? yes

23. SIGNATURE

Dr. Pademaher
Physician

M. D. or other

Address

Salisbury, mdDate signed 10/31/46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 25 1946

BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 389

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? two days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 304 Smith St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie Ellingsworth

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
6. (b) Name of husband or wife Preston Ellingsworth
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Sept. 30, 1859
8. AGE: Years 87 Months 0 Days 10 If less than one day _____ hrs. _____ min.

8. Birthplace Rockawalkin, Wicomico Co. Maryland
(Town, county, and state)10. Usual occupation at home

11. Industry or business

FATHER 12. Name George W. Byrd
13. Birthplace Wicomico, Co. Maryland
MOTHER 14. Maiden name Louisa Johnson
15. Birthplace Wicomico, Co. Maryland

16. Informant Miss Stella T. EllingsworthAddress Salisbury, Maryland17. Burial Date thereof Oct. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Parsons CemeteryLocation Salisbury, Maryland18. Funeral director The Hill & Johnson Co.Address Salisbury, Maryland19. 10/14 19 46 Harriet D. Johnson
(Date rec'd by registrar) (month) (year) Social Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1946 19 46 11:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 19 46 to Oct 10 19 46
and that I last saw him alive on Oct 10 19 46

Immediate cause of death

Chronic valvular Heart Disease

DURATION

6 yrs +

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Harriet D. Johnson M. D. or other
Address Salisbury Date signed Oct 11

RECEIVED
OCT 24 1946
KOREAN A.F.

Dr. Moyer

10454

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-0

CERTIFICATE OF DEATH



Reg. Dist. No. 3530

1. PLACE OF DEATH:

County: Wilkes County
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Penninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County: Sussex
City or town: Seaford
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Electwood

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
hrs. few min.

9. Birthplace: Salisbury Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name: Electwood Daniel Webster

13. Birthplace: Seaford Delaware

14. Maiden name: Rayne Mary Elling

15. Birthplace: Berlin Maryland

16. Informant

Address

17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location: Peninsula General Hospital

18. Funeral director

Address: Salisbury Maryland

19. 10/17 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29 - 1946 at 4:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/29 1946 to 10/29 1946 and that I last saw him alive on 1-2-29-1946

Immediate cause of death

Prematurely
Due to
Prenatal rupture
Due to
membrane

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Charles M. Moyer

M.D. or other

Address: Seaford Delaware Date signed: 12/1/46

MARGIN RESERVED FOR BINDING

VS-A15

9.4.5-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 2 1947

BUREAU 13

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3370

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43 days - 9 hrs - 15 mins

Hospital, institution, or street address where death occurred:

Peninsular General HospitalHow long in hospital or institution? 43 days - 9 hrs - 15 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 301. Lake Street
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Anna Dollie Freemy

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife William Freemy7. Birth date of deceased (mo., day, yr.) Aug. 10 - 18866.(c) If alive, give age 77 years8. AGE: Years 60 Months 2 Days 21 If less than one day..... hrs. min.9. Birthplace Sussex Co. Del.
(Town, county, and state)10. Usual occupation House wife11. Industry or business at home12. Name Benjamin F. Body13. Birthplace Sussex Co. Del.14. Maiden name Sallie C. Withers15. Birthplace Sussex Co. Del.16. Informant Mrs. J. William FreemyAddress 301. Lake St. Salisbury Md17. Burial (Burial, cremation, or reinterment. Which?) Burial Date thereof Nov 22 1946
(month) (day) (year)Cemetery or crematory Pyramid Cem.Location Salisbury Md18. Funeral director Hollman & Co. Walter R HollmanAddress Salisbury Maryland19. 11/21/46 Registrar Harriet E. Johnson

(Date certified by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31st 1946, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9/17 1946, to 10/31 1946and that I last saw him alive on 10/30 1946

Immediate cause of death.....

DURATION

Carcinoma of Liver secondary

Due to.....

Due to.....

Other conditions Carcinoma of Spleen, Gallbladder, Pancreas & Duodenum

(Include pregnancy within 3 months of death)

Major findings of operations Cholelithiasis, Carcinoma of Liver

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

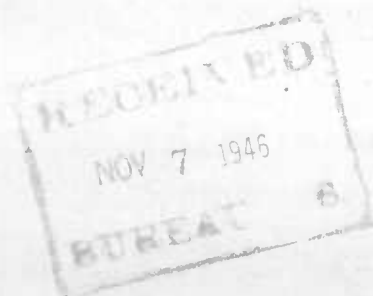
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Clayton Foster M. D. or otherAddress Salisbury Md Date signed 10/31/46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 1011333

1. PLACE OF DEATH: County <u>McComie</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>P. H. Hyatt</u> How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Ind</u> County <u>McComie</u> City or town <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Railroad Ave</u> (If rural, give LOCATION) 2.(c) If veteran, name war	
3. (a) FULL NAME <u>Linnus Edward Gredy</u>		3. (b) Social Security Number	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>	
6. (b) Name of husband or wife			
7. Birth date of deceased (mo., day, yr.) <u>March 14-1882</u> (c) If alive, give age <u>19</u> years			
8. AGE: Years <u>64</u> Months <u>6</u> Days <u>24</u> If less than one day hrs. min.			
9. Birthplace <u>Haristat Mo.</u> (Town, county, and state)			
10. Usual occupation <u>Farmer</u>			
11. Industry or business			
FATHER	12. Name <u>No. Record</u>		
	13. Birthplace <u>No. Record</u>		
MOTHER	14. Maiden name <u>No. Record</u>		
	15. Birthplace <u>Deceased gave this to wife. Welford Board</u>		
16. Informant Address <u>Salisbury Ind.</u> <u>Buried</u> Date thereof <u>Oct 10-1946</u> (Burial, cremation, or removal, which?) (month) (day) (year)			
Cemetery or crematory <u>Parson Cem.</u>			
Location <u>Salisbury Ind.</u>			
18. Funeral directors <u>Halliday & Co. Walter R. Halliday</u>			
Address <u>Salisbury Ind.</u>			
19. (Date rec'd by registrar) <u>10/9/46</u> <u>Harriet E. Johnson</u> Registrar			
MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Oct. 8th</u> 19 <u>46</u> at <u>9 a.m.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1945</u> to <u>act 8</u> 19 <u>46</u> and that I last saw him live on <u>act 6</u> 19 <u>46</u> Immediate cause of death <u>Chronic myocarditis</u> DURATION <u>2 yrs</u> Due to Due to Other conditions (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work? SIGNATURE <u>Harriet E. Johnson</u> M. D. or other Address <u>Salisbury Ind.</u> Date signed <u>act 9 46</u>			

RECEIVED

OCT 16 1945

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(181)

CERTIFICATE OF DEATH

Reg. Dist. No. 10416 339

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

26

6

4

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

10/15/46

10/15/46

10/15/46

10/15/46

10/15/46

10/15/46

10/15/46

10/15/46

10/15/46

10/15/46

10/15/46

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct. 15th

19

46, 11 a. M.

CERTIFY that death occurred on the date above stated: that I attended deceased from

and that I last saw him

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

Where and injury occurred

Near McCormick's

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Public Place

Injured at work?

No

23. SIGNATURE

M. D. or other

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 24 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

CERTIFICATE OF DEATH

Reg. Dist. No. 1119330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred H. S. B.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Bellevue
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hannon

3. (b) Social Security Number

4. Sex male 5. Color or race e 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) October 24 - 1946

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Salisbury, Maryland
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER	12. Name	<u>Hannon Walter Rogers</u>
	13. Birthplace	<u>Berlin, Maryland</u>
MOTHER	14. Maiden name	<u>Young Glouner Jane</u>
	15. Birthplace	<u>Accomac, Virginia</u>

16. Informant _____

Address _____

17. Cremation Date thereof Oct 24 - 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Peninsula Funeral HomeLocation Salisbury, Maryland

18. Funeral director _____

Address _____

19. 10/26/46 19. 46 Harriet O. Johnson Registrar
(Date rec'd. by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 - 1946 at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1946 to Oct 24 1946
and that I last saw him alive on Oct 24 1946

Immediate cause of death _____ DURATION

Pneumonia 6 mosDue to Caesarean Sectionor molar pregnancy

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

See R. M.22. SIGNATURE Harriet O. Johnson M. D. or other _____Address _____ Date signed 10/25/46

RECEIVED
NOV 7 1946
BUREAU V.E.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

10418

Reg. Dist. No. 792

1. PLACE OF DEATH *McComie*
 County *Salisbury*
 City or town *Salisbury*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution or street address where death occurred:
P.B. Hoyt
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For new-born infants give residence of mother)
McComie
 State *MD* County *Salisbury*
 City or town *Salisbury*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *604 Truitt St.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Henderson William Thomas

3. (b) Social Security Number

Sex *Male* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *Jan. 16-1946* 6.(c) If alive, give age years

8. AGE: Years *8* Months *2* Days *2* If less than one day

9. Birthplace *P.B. Hoyt, Salisbury Md.*
 (Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name *Ralph Lee Henderson*13. Birthplace *Pocomoke Md.*14. Maiden name *Margaret Jones*15. Birthplace *Salisbury Md.*16. Informant *Mrs. Margaret Henderson*Address *604 Truitt St. Salisbury Md.*17. Burial *Buried* Date thereof *Oct. 11-46*

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium *Presbyterian Cem.*Location *Salisbury Md.*18. Funeral director *William H. Miller*Address *Salisbury Md.*19. *10/9* 19. *46* Registrar *Barrie L. Johnson*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *8 October 1946* at *3:40 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *7 October 1946* to *8 October 1946* and that I last saw him alive on *8 October 1946*

Immediate cause of death *Bilateral bronchopneumonia 3 days*
 Due to *Cerebral paralysis since*
 Due to *Almost complete absence of frontal lobe of brain*
 Other conditions *Birth*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE *Barrie L. Johnson* M. D. or otherAddress *231 Camden Ave., Salisbury, Md.* Date signed *9 Oct. 1946*

RECEIVED

OCT 16 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 86

CERTIFICATE OF DEATH

Reg. Dist. No.

10419

#336

1. PLACE OF DEATH:

County Wicomico
 City or town Delmar R 7 D # 3
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Delmar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R 7 D # 3
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Harry Belle Holston

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Mar. 21-1912
 8. AGE: Years 34 Months Days If less than one day hrs. min.

9. Birthplace Warrenton County, Ore.
 (County, county, and state)
 10. Usual occupation None
 11. Industry or business None
 12. Name Geo. Holston
 13. Birthplace Williamsville, Del.
 14. Maiden name Sophia Wyatt
 15. Birthplace Berlin, Prus.

16. Informant Geo. Holston
 Address Delmar, Delaware
 17. Burial Date thereof Oct. 23-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Live Cemetery
 Location Williamsville, Del.
 18. Funeral director W. S. Grand Co.
 Address Delmar, Del.
October 23 1946 Harry E. Hudson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1946 at 4:45 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Oct 21 1946
 and that I last saw him alive on Oct 20 1946
 Immediate cause of death acute gastric
ulcer
 Due to E. coli
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

DURATION

10 days
20 min.

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. H. F. Z. nebi. M. D. or other
 Address Berlin, Prus. Date signed Oct 23/46

RECEIVED
OCT 28 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10420 337

1. PLACE OF DEATH:

County WicomicoCity or town Bisnake
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Bisnake MD
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George B. Harrison

3. (b) Social Security Number

4. Sex male5. Color or race white6.(a) Single, married, widowed, or divorced marriedB.(b) Name of husband or wife Emmie Harrison7. Birth date of deceased (mo., day, yr.) Jan 7 18778. AGE: Years 67 Months 9 Days 4 If less than one day _____ hrs. _____ min.6.(c) If alive, give age 63 yearsB. Birthplace Bisnake MD, Wicomico
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farm12. Name Geo. B. Harrison13. Birthplace Bisnake MD14. Maiden name Margaret Anderson15. Birthplace Bisnake MD16. Informant Mrs. Geo. B. HarrisonAddress Bisnake MD17. Burial Date thereof Oct 13 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bisnake MD - Cemetery

Location _____

18. Funeral director E. B. HarrisonAddress Bisnake MD19. Oct 13 1946 R. B. Harrison
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11th 1946 at 4p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946 to Oct 9 - 1946and that I last saw her alive on October 9th 1946

Immediate cause of death _____

DURATION _____

Due to Chronic Myocarditis

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William E. EnrichAddress Helder - MD M. D. or other _____Date signed Oct 13-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

Reg. Dist. No. 10421 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days - 9 hrs. 38 mins.
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 7 days - 9 hrs. 38 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State va County Wicomico
 City or town Oak Hall
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Oak Hall
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Keith, Baby Girl Parathy Jay Ann

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 26, 1946
 8. AGE: Years _____ Months _____ Days 8 If less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1946 at 1 am
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 Sept. 1946 to 4 Oct. 1946
 and that I last saw him/her alive on 3 October 1946
 Immediate cause of death Prematurity
 DURATION 7 days
 Due to Septicemia
 Due to Organism not determined at this time
 Other conditions
 (Include pregnancy within 3 months of death)

9. Birthplace Salisbury, Wicomico, Md.
 (Town, county, and state)
 10. Usual occupation None
 11. Industry or business
 12. Name Thomas N. Keith
 13. Birthplace Leva
 14. Maiden name Margaret LeBarre
 15. Birthplace Ida
 16. Informant Thomas N. Keith
 Address Oak Hall, Va.
 17. Burial Date thereof Oct 5, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Parsons Cemetery
 Location Salisbury, Md.
 18. Funeral director The Hill & Johnson
 Address Salisbury, Md.
 19. 10/5 1946 Theriot E. Johnson
 (Date rec'd by registrar) Registrar

Major findings of operations
 Autopsy results As above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of Injury _____ Injured at work? _____
 23. SIGNATURE Wickens, M.D.
 Address 2212 Canby Ave., Salisbury, Md.
 Date signed 5 Oct. 1946

RECEIVED
OCT 10 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Severnside General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County SevierCity or town Laurel
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hennery Mr. Edward C.

3. (b) Social Security Number

none4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Lillie V. Hennery7. Birth date of deceased (mo., day, yr.) 2/17/1862

6. (c) If alive, give age _____ years

8. AGE: Years 84 Months 8 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Delaware
(Town, county, and state)10. Usual occupation retired

11. Industry or business _____

12. Name John V. Hennery13. Birthplace Del.14. Maiden name Sallie Kinnickin15. Birthplace Del.16. Informant Mrs. Mary K. LinnAddress 320 East 11th St.
Sevier, D.C.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 10/22/46
(month) (day) (year)Cemetery or crematory Odd FellowsLocation Laurel, Del.18. Funeral director Harvey WilliamsonAddress Sevier, Maryland19. 10/36 19. 46 Harvey E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25- 19. 46, at 12:24 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7 19. 46 to Oct. 25 19. 46
and that I last saw him alive on Oct. 24 19. 46Immediate cause of death Cerebral Thrombosis DURATION 20 daysDue to Cerebral arteriosclerosis Symptoms 5 years

Due to _____ Symptoms _____

Other conditions arteriosclerotic heart disease 1 month
apnea
(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David J. Gilmore M.D. M. D. or otherAddress 301 N. Division St. Date signed _____
Salisbury, Md.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-2)

CERTIFICATE OF DEATH

10423

Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico
 City or town Wicomico Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
at home in Wicomico Maryland
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County New Castle
 City or town Wilmington Del
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 238 Millison St
 (If rural, give LOCATION)
 2. (a) If veteran, name war yes 1 and 2 ✓

3. (a) FULL NAME

Edward H. Lafferty

3. (b) Social Security Number

4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Annie Mae Lafferty
 6. (c) If alive, give age 53 years
 7. Birth date of deceased (mo., day, yr.) April 28, 1881

8. AGE: 65 Years 5 Months 4 Days If less than one day
 hrs. min.

9. Birthplace Wilmington Del.
 (Town, county, and state)

10. Usual occupation mechanic

11. Industry or business machine shop

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Catherine

15. Birthplace Unknown

16. Informant wife

Address Wicomico Maryland

17. Burial Date thereof Oct 4, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Hope (near Wicomico)

Location Wicomico County

18. Funeral director Mr. Rasha Watson

Address Seaboard Delaware

19. 10/3 19 46 Harriet P. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2nd 19 46 at 5:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 19 46 to day of death 19 46 and that I last saw him alive on 10-2-46

Immediate cause of death acute myocarditis DURATION 2 days

Due to

Due to

Other conditions Septicemia

Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank R. Lewis M.D.

M. D. or other

Address Wilmington Del. Date signed 10-2-46

RECEIVED

OCT 10 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH: Tyaskin, Md
 County Wilcomico
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State md. County Wilcomico
 City or town Tyaskin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2(a) If veteran, name war.

3. (a) FULL NAME
Daniel Henry Lord

3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced widower
 6. (b) Name of husband or wife Rebecca C. Lord

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1858 B. (c) If alive, give age years

8. AGE: Years 87 Months 10 Days 25 If less than one day
 hrs. min.

9. Birthplace Vienna, Wilcomico, Md
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Henry Clay Lord
 13. Birthplace Don't know

MOTHER 14. Maiden name Mary Carroll
 15. Birthplace Don't know

16. Informant Mrs. Ethel Hurley
 Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 10/20/46
 (month) (day) (year)

Cemetery or crematory Cemetery
 Location Tyaskin, Md

18. Funeral director J. C. Messick
 Address Bivalve, Md.

19. Oct 20 19 46 R. R. Walter
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 19 46 at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 19 46 to October 16 19 46
 and that I last saw him alive on October 16 19 46

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions arteriosclerosis
 (Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE William Furich
Holbrook, Md M. D. October
 Address Date signed Oct 20-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333 6

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 37 years
 Hospital, institution, or street address where death occurred: P.B. Hosp.
 How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1396 E. Main st.
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Emmett Milton Merrick
Marielana E. Wilton

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

6. (b) Name of husband or wife Beauregard Merrick

7. Birth date of deceased (mo., day, yr.) March 25, 1872 6. (c) If alive, give age Dead years

8. AGE: Years 74 Months 6 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace near Cambridge Md.
 (City, county, and state)

10. Usual occupation Club

11. Industry or business Wilson Merrick

12. Name Dochester Co. Md.

13. Birthplace (unknown) Hurley

14. Maiden name Dochester Co. Md.

15. Birthplace Mrs. Bea Merrick Chamber

16. Informant 433 E. State St. Greentown N.J.

17. Burial Wicomico Mem. Park

18. Cemetery or crematorium Salisbury Maryland

19. Funeral director Helmsway & Kester R. Helmsway

Address Salisbury Md.

10/26/46

18/26/46

18/26/46

18/26/46

18/26/46

18/26/46

MEDICAL CERTIFICATION

D. DATE OF DEATH October 24, 1946 at 12:05 M

I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18, 1946 to October 24, 1946

and that I last saw him alive on 24, October 1946

Immediate cause of death Carcinomatosis

Due to Primary site for Bowel & Liver

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations metastatic Carcinoma Liver

Date of op. 10/22/46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

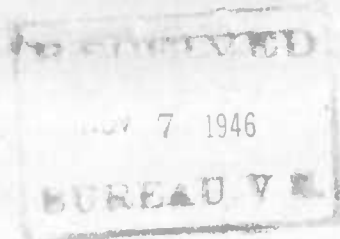
Means of injury _____ Injured at work? _____

Signature William B. Long M.D.

Address 504 N. Division St. Salisbury, Md.

Date signed 24 Oct. 1946

18/26/46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifetimeHospital, institution, or street address where death occurred:
P.B. Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For non-born infants give residence of mother)

State MD. County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 202 Locust Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Oscar Lerim Moore

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Bettie Moore7. Birth date of deceased (mo., day, yr.) June 14-18836.(c) If alive, give age 66 years8. AGE: Years 63 Months 4 Days 0 If less than one day
hrs. min.9. Birthplace Salisbury, Maryland
(Town, county, and state)10. Usual occupation Painter11. Industry or business House Painting12. Name William Moore13. Birthplace Greenwood Delaware14. Maiden name Mary E. Humphreys15. Birthplace Marbleton Maryland16. Informant Mrs. Bettie MooreAddress 202 E. Locust St. Salisbury, Md.17. Burial (Burial, cremation, or removal) Buried Date thereof Oct. 17 & 18

(Month) (day) (year)

Cemetery or crematory Parson Cem.Location Salisbury Maryland18. Funeral director Holloman & G. Walter R. HollomanAddress Salisbury Maryland19. 10/16/46 H. E. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 19 46 at 6:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 14 19 45 to Oct. 14 19 46and that I last saw him alive on Oct. 14 19 46

Immediate cause of death

Carcinoma of Rectum

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Salisbury Md Date signed 10-14-46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10427 333

1. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Salisbury Peninsula Gen. Hosp.
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Worcester
 City or town... Stockton Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) _____
 2.(a) If veteran, name war _____

3. (a) FULL NAME

P. Snow Parsons Sr

3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Jennie Jones Parsons

7. Birth date of deceased (mo., day, yr.)

August 31 1872

6. (c) If alive, give age

67 years

8. AGE:

Years

Months

Days

If less than one day

7410

hrs.

min.

9. Birthplace

Stockton Worcester Md.
(Town, county, and state)

10. Usual occupation

Hydr. planter

11. Industry or business

12. Name

John P. Parsons

13. Birthplace

Maryland

14. Maiden name

Mary Elizabeth Jones

15. Birthplace

Maryland

16. Informant

Thomas Andy Parsons Jr.Address 1128 E. Church St., Salisbury Md.

17. Burial

Burial Date thereof Oct 4 1946
(month) (day) (year)

Cemetery or crematory

Episcopal Cemetery

Location

Stockton Md.

18. Funeral director

Henry H. Watson

Address

Pocomoke City Md.

19. Date rec'd by registrar

10/4/46

(Date rec'd by registrar)

19. 4/6

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct 1 1946 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5 Sept 1946 to 1 Oct 1946and that I last saw h. / m. alive on 1 Oct 1946

Immediate cause of death

MassiveCerebral Hemorrhage

DURATION

4 weeksDue to atherosclerosisgeneralized

Due to

Other conditions

Uremia due tohypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hermana Rappin M.D.

M. D. or other

Address

Shaw Hill, Md.Date signed 20 Oct 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 10 1946
BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

Reg. Dist. No. 338

10428

1. PLACE OF DEATH:

County.....Wicomico
 City or town.....Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....2 month
 Hospital, institution, or street address where death occurred:
Hillside Dr.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Wicomico
 City or town.....Hebron
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

Zenobia F. Phillips

3. (b) Social Security Number

4. Sex.....female 5. Color or race.....white 6. (a) Single, married, widowed, or divorced.....widowed
 6. (b) Name of husband or wife.....Andrew J. Phillips
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....Oct. 12, 1884
 8. AGE: Years.....82 Months.....0 Days.....7 If less than one day..... hrs. min.

9. Birthplace.....Wicomico Co. Maryland
 (Town, county, and state)
 10. Usual occupation.....at home
 11. Industry or business.....
 12. Name.....Sam Howard
 13. Birthplace.....Wicomico Co. Maryland
 14. Maiden name.....Mary Taylor
 15. Birthplace.....Wicomico Co. Maryland
 16. Informant.....Mr. Norman Phillips

Address.....Hillside Dr. Salisbury, Maryland.
 17. burial Date thereof.....Oct. 21, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Hebron, Cemetery
Hebron, Maryland.
 Location.....
 18. Funeral director.....The Hill & Johnson Co.
 Address.....Salisbury, Maryland.

19. 10/21, 46 Registrar.....Barrett J. Johnson
 (Date rec'd by registrar) Address.....Salisbury

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Oct. 19, 1946 at 5 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept 15, 1946 to Oct 19, 1946
 and that I last saw her alive on Sept 15, 1946

Immediate cause of death.....Carcinoma colon DURATION.....2
 Due to.....Chronic myocarditis.....2
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE.....Norman M. D. M. D. or other.....
 Address.....Salisbury Date signed.....10/20/46

MARGIN RESERVED FOR BINDING

VS A15

9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 24 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10429-333

1. PLACE OF DEATH:

County WorcesterCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Purnell Baby Boy, Baby

3. (b) Social Security Number

4. Sex Male 5. Color or race C 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

10-6-46

8. AGE:

Years

Months

Days

If less than one day

8

hrs. min.

9. Birthplace Whaleville, Worcester Co., Maryland
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name William T. Purnell13. Birthplace Berlin, Maryland14. Maiden name Effie Triett15. Birthplace Snow Hill, Maryland16. Informant William T. PurnellAddress Berlin, Maryland17. Burial
(Burial, cremation, or removal, Which?)Date thereof 10-15-46
(month) (day) (year)Cemetery or crematory St. JamesLocation near Berlin, Maryland18. Funeral director James F. StewartAddress 402 E. Church St. Salisbury, Md.19. 10/15 19 46 Harriet E. Johnson
(Date filed by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 19 46, at 5:38 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

act 6 19 46, to act 14 19 46

and that I last saw him alive on _____ 19 _____

Immediate cause of death

DURATION

Premature Birth 8 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE W. Wanner M.D.

M. D. or other

Address Salisbury Date signed act 15

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

1110

Comm.

ARTISTIAN LEO 320

NO RAC CONTENT

RECORDED
OCT 24 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 934

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:

County Wicomico
 City or town Mardela Springs - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
San Domingo
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Mardela Springs - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. San Domingo
 (If rural, give LOCATION)
 2.(d) If veteran, name war

3. (a) FULL NAME

M. Eliza Quinton

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife George Quinton
 6.(c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) February 26, 1882
 8. AGE: Years 64 Months 7 Days 5 It less than one day hrs. min.

9. Birthplace Wicomico County, Maryland
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business Home
 12. Name Leonard Gaines
 13. Birthplace Wicomico County, Maryland
 14. Maiden name Martha Ennis
 15. Birthplace Wicomico County, Maryland

16. Informant George Quinton
 Address Mardela Springs, Maryland, R.F.D.
 17. Burial Date thereof October 5, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory San Domingo Cemetery
 Location Near Sharptown, Maryland
 18. Funeral director J. J. Frampton and son
 Address Federalsburg, Maryland
 19. Oct 5 19 46 Walter G. Mann
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1946 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-1 19 46 to 10-1 19 46
 and that I last saw him alive on 10-1 19 46

Immediate cause of death DURATION
Cerebral thrombosis
 Due to Arteriosclerosis, Cerebral
 Due to Vascular disease
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE Charles M. Moya, M.D. M. D. or other
Laurel R. Date signed 10/13/46

RECEIVED
OCT 8 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 780

CERTIFICATE OF DEATH

10431

Reg. Dist. No. 233

1. PLACE OF DEATH:

County Wicomico
City or town Eden
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Eden
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Berlina Johnson Savage

3.(b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1896 6.(c) If alive, give age years

8. AGE: Years 50 Months Days It less than one day hrs. min.

9. Birthplace Accomack County, VA
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business House

12. Name Berlina Johnson

13. Birthplace Accomack Co. VA

14. Maiden name Emma Johnson

15. Birthplace Accomack Co. VA

16. Informant George J. Savage

Address Eden, Maryland

17. Burial Date thereof October 22, 1946
(Burial, cremation, or removal. Write month) (day) (year)

Cemetery or crematory Shiloh Cemetery

Location Boston, VA

19. Funeral director J. Edgar Thomas

Address Accomack, VA

19. 10/20 19 46 Registrar Barrie F. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1946 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-7 19 46 to 10-19 19 46

and that I last saw her alive on 10-17 19 46

Immediate cause of death Hypertensive heart diseases

DURATION

2

Due to

Due to

Other conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Russell MD.

Address 880 W. Main Street M. D. or other

Date signed 10-19-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

RECEIVED
OCT 24 1946
BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 10432 3330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution?

5 days

3. (a) FULL NAME

Shockley Mrs. Grace

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Louis H. Shockley

7. Birth date of deceased (mo., day, yr.)

June 22 18876. (c) If alive, give age 69 years

8. AGE:

Years

59

Months

4

Days

0

If less than one day

hrs.min.

9. Birthplace

Stie Md

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Thomas St. English

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. 4/6. Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Stie

City or town

Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

October 22 - 1946 at 8:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Carcinoma of sigmoid colon

DURATION

Due to

Due to

Other conditions

Acute myocardial infarction

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma of sigmoid colon
Acute myocardial infarction Date of op. 10-17-46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

William B. Long4 M Dr. St.Salisbury, Md.

M. D. or other

Date signed 10/22/46

RECEIVED
NOV 7 1946
BUREAU V.B.

2-35

ARTESIAN LEDGER

PRO CONCERT

★

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 16 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

10434

Reg. Dist. No. 9330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)Street No. 907 Second St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Sturgis (Twin #1)

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Newborn

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

few hrs.

min.

9. Birthplace

Salisbury, Wicomico, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

18. Informant

Address

17. cremation

(Burial, cremation, or removal. Which?)

Date thereof

October 21, 1946
(month) (day) (year)

Cemetery or crematory

Peninsula General Hosp

Location

Peninsula General Hospital

18. Funeral director

Address

Salisbury, Maryland19. 10/2119. 46

(Date read by registrar)

Barrie E. Hughes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 19 46, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-17 19 46, to 10-17 19 46.and that I last saw her alive on 10-17 19 46.

Immediate cause of death

Respiratory failurePrematurity38 wks.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

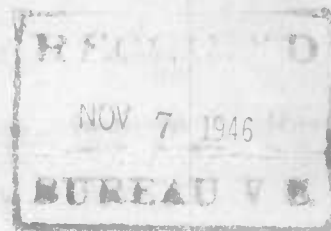
Injured at home, farm, industry, public place (where?) _____

Means of Injury _____

Injured at work? _____

23. SIGNATURE

Robert R. Starr
M. D. or otherAddress Salisbury Date signed 10-17-46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

10435
Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 weeks

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 59 days (incl. 5 min.)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WarcesterCity or town Berlin Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Trappe Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Wainwright

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Lemuel Wainwright

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 18798. AGE: Years 67 Months _____ Days _____ If less than one day

_____ hrs. _____ min.

9. Birthplace Berlin R.F.D. Wor. Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jacob Lynch13. Birthplace Berlin R.F.D. Md14. Maiden name Sally M. Quillen15. Birthplace Berlin R.F.D. Md.16. Informant Annie AydelotteAddress Berlin, Md.17. Borial Date thereof Oct 13, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Taylorville CemeteryLocation Berlin R.F.D.18. Funeral director Anna A. BurlageAddress Berlin Md.19. 10/13/46 19 46 Harriet E. Johnson Registrar(Date rec'd by registrar) (month) (day) (year) Address Salisbury Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1946, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 8, 1946 to Oct 11, 1946and that I last saw h.f.x. alive on Oct 11, 1946

Immediate cause of death

Diabetes mellitus

Due to

Due to

Other conditions Diabetic gangrene ofleft foot.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Harriet E. Johnson

M. D. or other

Address Salisbury Md.Date signed 10-12-46

RECEIVED
OCT 24 1946
HONOLULU